

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4
 may be signed by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12460

1. PLACE OF DEATH a. COUNTY Calvert		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland		b. COUNTY St. Mary's	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN 1b 16 days		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural		d. STREET ADDRESS Mechanicsville	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Frederick Nursing Home							
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
3. NAME OF DECEASED (Type or print)	First Albert	Middle A.	Last Burroughs	4. DATE OF DEATH	Month November	Day 21	Year 1960
S. SEX Male	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH Dec. 24, 1881	9. AGE (In years last birthday) 78 yrs.	IF UNDER 1 YEAR Months 0	IF UNDER 24 HRS. Days 0	Hours 0
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farming		10b. KIND OF BUSINESS OR INDUSTRY Farm		11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME William Thomas Burroughs		14. MOTHER'S MAIDEN NAME Mary M. Bond					
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 217-36-6686		17. INFORMANT E. Ray Burroughs		Address Mechanicsville, Maryland	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 153.8 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		DUE TO		<i>Carcinoma of Colon</i>		INTERVAL BETWEEN ONSET AND DEATH 1 month	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) : 		20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from Nov 11 1960 to Nov 21 1960 that (I) (we) last saw the deceased alive on Nov 19 1960 and that death occurred at M. from the causes and on the date stated above.							
22a. SIGNATURE <i>Page C. Jett</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED 11/24			
22c. PHYSICIAN'S NAME (Type) PAGE C. JETT		22d. ADDRESS <i>Prince Frederick</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11/23/60		23c. NAME OF CEMETERY OR CREMATORIUM All Faith Cemetery		23d. LOCATION (City, town, or county) (State) Charlotte Hall, Maryland	
24. FUNERAL DIRECTOR'S SIGNATURE <i>W. Clarke Mattingley</i>		ADDRESS Leonardtown, Maryland		25a. REC'D BY REGISTRAR DATE NOV 23 '60		25b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i>	

100

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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55-50A

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12422

CERTIFICATE OF DEATH

12401

Reg. Dist. No.

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY CARTERT		MARYLAND		STATE MD.		COUNTY CHARLES LA PLATA	
CITY (If outside corporate limits, write RURAL OR end, give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)		STREET ADDRESS - (If rural give location)	
TOWN PRINCE FREDERICK		WEEKS		TOWN LA PLATA		C8X-2	
HOSPITAL OR INSTITUTION OR STREET ADDRESS CARTERT NURSING HOME							
3. NAME OF DECEASED (Type or Print) FRANK E COOKSEY				4. DATE (Month) (Day) (Year) OF DEATH Nov 1 1960			
5. SEX M	6. COLOR OR RACE W	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) MARRIED	8. DATE OF BIRTH Feb 9 1878	9. AGE last birthday 82 yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) FARMER				10b. KIND OF BUSINESS OR INDUSTRY FARMING.	11. BIRTHPLACE (State or foreign country) La Plata Md.		
13. FATHER'S NAME HAWKINS COOKSEY				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) No				16. SOCIAL SECURITY NO. NONE	17. INFORMANT & ADDRESS La Plata, MD. Mrs Wallace Barnes		
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH 33IX IMMEDIATE CAUSE ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, (B) GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)				HYPER TENSIVE C.U. DISEASE CEREBRAL HEMORRHAGE JULY 1960			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. DECUBITUS ULCERS							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County)		(State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from Nov 1, 1960, to Nov 1, 1960, that I last saw the deceased alive on Nov 1, 1960, and that death occurred at M, from the causes and on the date stated above. SIGNATURE Frances J. Deppert 11/1/60							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		DATE THEREOF 11-4-60		NAME OF CEMETERY OR CREMATORIUM Mt Rest		LOCATION (City, town, or county) La Plata, Md.	
24. REC'D BY REGISTRAR DATE NOV 7 '60		REGISTRAR'S SIGNATURE Carrie S. Kuhn		25. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hunt Funeral Home, Melton, Md.			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PH3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

V.S. A15ME(5)
5M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12423 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

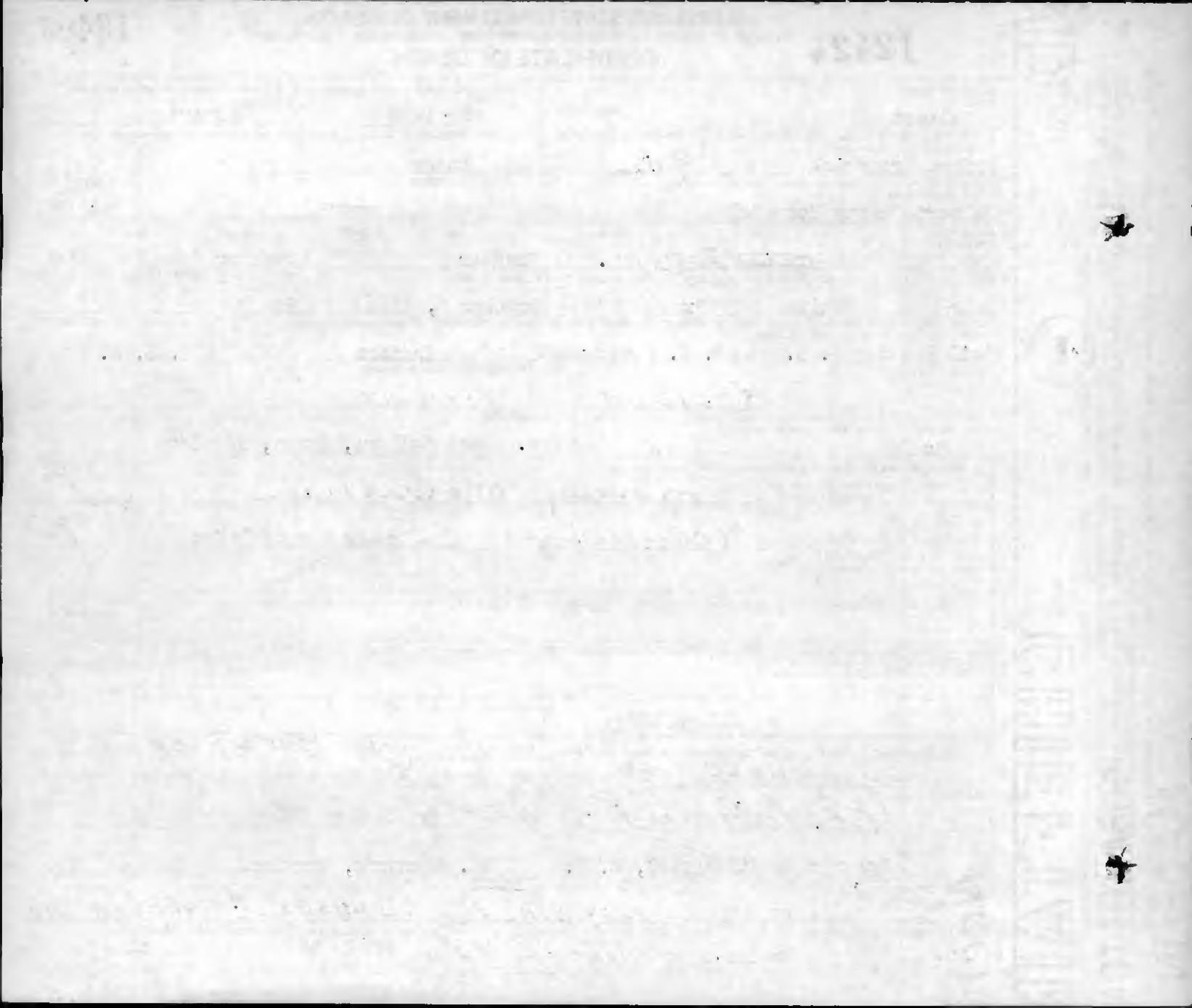
12462

1. PLACE OF DEATH a. COUNTY Cabot MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE Md b. COUNTY Calvert	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick		c. LENGTH OF STAY IN TB 2 da	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Calvert Co.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Zena J. Hammeth		First	Middle
		Last	DATE OF DEATH 11 29 1960
4. SEX F	5. COLOR OR RACE W	6. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> 7. WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH Aug. 3, 1887 9. AGE (In years from birthday) 73 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Home	11. BIRTHPLACE (State or foreign country) Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME Robert D. Hite		14. MOTHER'S MAIDEN NAME Eugene Buchanan Address	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 780-3-12345 17. INFORMANT Mary H. Schoenenger - Florida	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 916. DUE TO <u>Bereavement</u> <u>Pneumonia</u> Conditions, if any, which gave rise to immediate cause (b) <u>Inhalated burns of arms &</u> (c) <u>face</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c). 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Dental shoe exploded</u>			
20c. TIME OF INJURY Month, Day, Year Hour 3 p.m. 11/27/60		20d. INJURY OCCURRED White Not white at work <input type="checkbox"/> or work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Bowen Building</u> 20f. CITY OR TOWN (County) <u>Baltimore</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <u>H. W. Ward</u>		DATE SIGNED <u>11/28/60</u>	
EXAMINER'S NAME (Type) <u>H. W. WARD</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF Dec. 2, 1960	22c. NAME OF CEMETERY OR CREMATORIUM Our Lady Star of the Sea Solomons
22d. LOCATION (City, town, or county) <u>Md.</u> (State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>A. G. Hackness & Son - Mutual, Md.</u>		ADDRESS	24a. REC'D BY REGISTRAR DEC 2 '60 DATE,
		24b. REGISTRAR'S SIGNATURE <u>John S. Kline</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician and completely filled in by the funeral director.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND												12493		
1. PLACE OF DEATH a. COUNTY Calvert						2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE MARYLAND								
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Prince Frederick			c. LENGTH OF STAY IN 1b 9 da			d. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Lusby			e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Calvert County Hospital						d. STREET ADDRESS								
3. NAME OF DECEASED (Type or print)		First Jewell	Middle JERRY N.	Last Kreider	4. DATE OF DEATH November 20 1960	Month November	Day 20	Year 1960						
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>	8. DATE OF BIRTH October 6, 1866	9. AGE (In years last birthday) 94 yrs.	IF UNDER 1 YEAR Months 9		IF UNDER 24 HRS. Days 1		Hours 0				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Civil Service U. S.			10b. KIND OF BUSINESS OR INDUSTRY U. S. Government			11. BIRTHPLACE (State or foreign country) Indiana			12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME KREIDER						14. MOTHER'S MAIDEN NAME UNKNOWN								
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No			16. SOCIAL SECURITY NO. No			17. INFORMANT Mrs. Ethel Sollars, Lusby, Maryland			Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]									INTERVAL BETWEEN ONSET AND DEATH 10 days					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 420.1			DUE TO Coronary occlusion											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. Generalized arterio-sclerosis			(b) DUE TO 10 days											
(c)														
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)												19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Hour o. m. p. m. 19			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from Nov 10 1960 to Nov 20 1960 , that (I) (we) last saw the deceased alive on Nov 20 1960 , and that death occurred at 9:00 A.M. from the causes and on the date stated above.														
22a. SIGNATURE Roberto de Villarreal			M.D. <input type="checkbox"/> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22b. DATE SIGNED 11/20/60					
22c. PHYSICIAN'S NAME (Type) Roberto de Villarreal, M. D.			22d. ADDRESS St. Leonards, Maryland											
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE THEREOF Nov. 23, 1960		23c. NAME OF CEMETERY OR Crematory CALVARY BIBLE CHURCH LUSBY - CALVERT CO - MD		23d. LOCATION (City, town, or county) St. Leonards, Maryland		(State)						
24. FUNERAL DIRECTOR'S SIGNATURE A.A. HARKNESS & Son - Mutual, MD			ADDRESS			25a. REC'D BY REGISTRAR DATE NOV 23 '60		25b. REGISTRAR'S SIGNATURE G. Lee S. Knapp						



MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12425

CERTIFICATE OF DEATH

Reg. Dist. No.

12404

1. PLACE OF DEATH a. COUNTY <i>CALVERT</i>		MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>MD</i>		b. COUNTY <i>CALVERT</i>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. LEONARD'S</i>		c. LENGTH OF STAY IN lb <i>LIFE</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>ST. LEONARD'S</i>						
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION —		d. STREET ADDRESS —		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print)	First <i>JOHN</i>	Middle <i>GODFREY</i>	Last <i>LONG</i>	4. DATE OF DEATH	Month <i>Mov.</i>	Day <i>22</i>	Year <i>1960</i>			
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>SEPT. 26, 1896</i>	9. AGE (In years lost birthday) <i>64 yrs.</i>	IF UNDER 1 YEAR Months <i>—</i>	IF UNDER 24 HRS. Days <i>—</i>	HOURS <i>—</i>	Min. <i>—</i>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>FISHING</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>WATERMAN</i>		11. BIRTHPLACE (State or foreign country) <i>CALVERT CO., MD</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
13. FATHER'S NAME <i>EDWARD LONG</i>		14. MOTHER'S MAIDEN NAME <i>MAGGIE BOWEN</i>		Address						
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>218-09-3975</i>		17. INFORMANT <i>ANNIE LONG - ST. LEONARD'S, MD.</i>						
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary disease</i>		DUE TO <i>420.0</i>		INTERVAL BETWEEN ONSET AND DEATH <i>—</i>						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>—</i>		(b) DUE TO <i>—</i>		(c) <i>—</i>						
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> or work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>—</i>		20f. (City or town) <i>—</i>		(County) <i>—</i>	(State) <i>—</i>	
21. I certify that I attended the deceased from <i>8-7-1949</i> to <i>22 Nov 1960</i> , that I last saw the deceased alive on <i>22 Nov 1960</i> , and that death occurred on <i>13 Nov 1960</i> , from the causes and on the date stated above.										
ACTUAL SIGNATURE <i>G. J. Weems</i>		ADDRESS (Street, city or town, state) <i>M.D. Huntington, Md</i>								DATE SIGNED <i>1/24/60</i>
PHYSICIAN'S NAME (Type) <i>G. J. WEEMS</i>										
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		22b. DATE THEREOF <i>NOV. 25, 1960</i>		22c. NAME OF CEMETERY OR CREMATORIUM <i>MIDDLEBURN CHAPEL CEM., LOSBY</i>		22d. LOCATION (City, town, or county) <i>MD</i>		(State)		
23. FUNERAL DIRECTOR'S SIGNATURE <i>A. A. HARKNESS & SON - MUTUAL, MD.</i>		ADDRESS		24a. REC'D BY REGISTRAR DATE <i>NOV 28 '60</i>		24b. REGISTRAR'S SIGNATURE <i>Arthur S. Thomas</i>				

CREATIVE STYLING



1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12405

Reg. Dist. No.

12426

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending", in pencil in item 1B. Give Pages 1, 2, and 3 to the Funeral Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial or removal.

1. PLACE OF DEATH a. COUNTY <i>Calvert</i>		2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <i>Maryland</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>W. Beach</i>		c. LENGTH OF STAY IN TB <i>W. Beach</i>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>Carl Ernest O'Dell</i>		4. DATE OF DEATH <i>11 Month 19 Day Year 1960</i>	
5. SEX <i>M</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>31-7-1920</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>	11. BIRTHPLACE (State or foreign country) <i>W. Va</i>
13. FATHER'S NAME <i>Wm O Dell</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, unknown) <i>Yes Army</i>		16. SOCIAL SECURITY NO. <i>212-18-9163</i>	17. INFORMANT <i>Mrs. Carl O'Dell W. Beach Key</i>
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Crushed skull, head</i>		INTERVAL BETWEEN ONSET AND DEATH <i>823 X</i>	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>Card. ley</i>			
DUE TO (b) <i>Card. ley</i>			
DUE TO (c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>Crush accident</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <i>Crush accident</i>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.) <i>Crush accident</i>	
20c. TIME OF INJURY Month, Day, Year <i>4:45 p.m. 11/19 1960</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <i>W. Beach Calvert MD</i>
20f. (City or town) <i>W. Beach Calvert MD</i>		(County) <i>MD</i>	
(State) <i>MD</i>			
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <i>H. W. Ward</i>		DATE SIGNED <i>11/19/60</i>	
EXAMINER'S NAME (Type) <i>H. W. Ward, Owings, Maryland</i>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>11-23-60</i>	22c. NAME OF CEMETERY OR CREMATORIUM <i>Mt Harmony</i>
22d. LOCATION (City, town, or county) <i>W. Owings Md.</i>		(State) <i>MD</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Hutchins Funeral Home Owings, Md.</i>		24a. REC'D BY REGISTRAR <i>NOV 22 '60</i>	24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kress</i>

OF COMMERCIAL BANKS TO THE UNITED STATES GOVERNMENT

LETTERS TO THE CHIEF OF POLICE - DEPT. OF JUSTICE

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If a delay is necessary, please initial the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill Pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 24 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12427

1. PLACE OF DEATH a. COUNTY CALVERT		2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Prince Frederick		b. COUNTY CALVERT	
c. LENGTH OF STAY IN 1b Life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Barstow	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Calvert County Hospital		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) ORVILLE LESTER OGDEN		First Middle Last	4. DATE OF DEATH November 8 1960
5. SEX Male		6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		8. DATE OF BIRTH 8/22/58	
10b. KIND OF BUSINESS OR INDUSTRY infant		9. AGE (in years last birthday) 2 yrs.	
11. BIRTHPLACE (State or foreign country) Calvert Ct., Md.		10. IF UNDER 1 YEAR Months 2 Days 0 Hours 0 Min. 0	
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME Benjamin Ogden	
14. MOTHER'S MAIDEN NAME Elizabeth Buckler		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> (If yes, give rank or date of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Benjamin Ogden Barstow, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration of vomitus.		Address	
DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Aspiration of stomach content.	
20c. TIME OF INJURY Month, Day, Year Hour 3:00 p.m. Date 11/8/60		20d. INJURY OCCURRED <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/> Home	
20f. (City or town) Barstow		(County) Calvert, Md.	
(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>	
ACTUAL SIGNATURE <i>William V. Lovitt</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
EXAMINER'S NAME (Type) William V. Lovitt, Jr., M.D.		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) Buried		DATE SIGNED November 9, 1960	
22b. DATE THEREOF Nov. 11, 1960		22c. NAME OF CEMETERY OR CRÉMATORIUM Wesley Cemetery	
23. FUNERAL DIRECTOR G. O. Hackness & Son - Mutual, Md.		22d. LOCATION (City, town, or county) Prince Frederick, Md.	
ADDRESS		(State)	
24a. REC'D BY REGISTRAR NOV 14 '60		24b. REGISTRAR'S SIGNATURE Arthur S. Kline	
DATE			

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